STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968705	**09/19/2018**
NAME OF PROVIDER OR SUPPLIER **SANTA SUSANA ASSISTED LIVING FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **11407 LARKWOOD WAY** **TAMPA, FL 33625**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

A biennial licensure survey was conducted on . . . . . at Santa Susana Assisted Living Facility (License #12568), an assisted living facility in Tampa, Florida. There were deficiencies identified at the time of visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to maintain or produce documentation of a medical examinations by a healthcare provider after a significant change that included admission to hospice, and failed to review and follow-up with providers to ensure that the resident health assessments were free and completed accurately for two (Resident #2, and Resident #5) of three residents selected for record review.

Findings included:

Review of health assessment (AHCA Form 1823, . . 2017), dated , on . . . . . for Resident #2 revealed that the assessment indicated that Resident #2 required medication administration. Record review revealed that Resident #2 was admitted to hospice on . . . . . , there was no evidence of a health assessment conducted post admittance to hospice on .

Review of undated health assessment (AHCA Form 1823, 2017), on for Resident #5 revealed that the assessment indicated that Resident #5 required assistance with medication self-administration. Record review revealed that Resident #5 was admitted to hospice on , there was no evidence of a health assessment conducted post admittance to hospice on . . . . . . Sticker on assessment indicated that assessment was completed on .

During observation of assistance with medication self-administration, with Staff B, on , at 12:06 p.m., Resident #2 was able to self-administer medication with assistance.

On . . . . . , at 12:17 p.m., Staff B was observed administering oral dosage of scheduled medication for Resident #5. Administrator and Facility nurse who was present, confirmed that Resident #5 needed medication administration.

During record review, on . . . . . at 06:02 p.m., with the Administrator and Facility Nurse, they

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confirmed that no health assessment was conducted for Resident #2, and Resident #5 after admission to hospice. Administrator also confirmed that assessment for Resident #5 indicated that the resident needed assistance with self-administration, and was missing the date and information for the provider who conducted examination.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. Specifically, unlicensed staff (Staff B) administered oral medication, failed to verify one resident swallowed the prescribed medications provided, and failed to crush medication for a resident that required crushed medications for one (Resident #5) of four resident observed for assistance with medication self-administration.

Findings included:

During an observation of assistance with self-administration of medication with Staff B, on [redacted] at 12:19 p.m., Staff B (an unlicensed caregiver) administered the medication dosage by spoon feeding the tablet to Resident #5.

On [redacted] at 12:23 p.m., Resident #5's mouth was observed with the tablet slightly dissolved, resting on the bottom row of Resident #5's [redacted]. Administrator conformed that Staff B should have ensured that Resident #5 swallowed the medication tablet.

On [redacted] at 12:24 p.m., the Administrator provided Resident #5 with additional drinks of water, and verified that Resident #5 swallowed the oral dosage.

Review of physician orders, dated [redacted], revealed that per the orders, medications for Resident #5 were to be crushed and placed in applesauce.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to ensure that only licensed staff administered medications to one (Resident #5) of four observed for assistance with medication

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self-administration.

Findings included:

During an observation of assistance with self-administration of medication with Staff B, on at 12:19 p.m., Staff B administered medication dosage by spoon feeding the tablet to Resident #5.

On at 12:23 p.m., the Administrator who was present confirmed that Resident #5 needed medication administration and that unlicensed staff administered medication for Resident #5.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, record review and interview, the facility failed to provide annual documentation of a negative ( ) examination for two employees (Administrator and Staff A, and Staff B), and no freedom of communicable statement for one (Staff C) of three employees selected for review.

Findings included:

Record review for the Administrator, on , revealed that the most recent documentation related to was on . There was no evidence of annual documentation of a negative examination.

Record review for Staff C, on , revealed that the most recent documentation related to was an X-ray conducted on . There was no evidence of annual documentation of a negative examination. There was no documented evidence of freedom of communicable statement for Staff C.

On , at 01:46 p.m., Administrator and Facility Nurse reviewed the records and confirmed that Staff C did not have a documented statement indicating freedom of communicable , and confirmed that Staff C did not have a more recent examination that .

On , at 02:17 p.m., the Administrator reviewed records and confirmed that the last examination for the Administrator, who provided assistance with direct care, was dated .

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Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and interview, the facility failed to ensure that staff who worked alone with the residents completed First Aid and ( ) training for four employees (Administrator, Staff A, Staff B, and Staff C) of seven employees who worked at the Facility.

Findings included:

Employee record review on revealed that First Aid/ training was provided by the Facility Nurse for the Administrator, Staff A, Staff B, and Staff C. Record review revealed no indication that the Facility nurse was approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education.

Review of Staffing schedule with Administrator, on at 02:17 p.m. revealed multiple shifts worked by two of the employees who had First Aid/ did not have an approved First Aid/ certification.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview, the Facility failed to produce written notification of the Facility's comprehensive emergency management plan approval and implementation to residents and/or residents' legal representative for six of six residents (Residents #1-6) who reside at the facility; Facility failed to store a minimum of 48 hours of fuel for generator, in the event loss of primary electrical power; and failed to maintain or furnish a policy and procedure for the approved and established emergency power plan.

Findings included:

Record review, conducted on , revealed the Facility's comprehensive emergency management plan was reviewed and approved on by the local Office of Emergency Management, with emergency power plan implementation date on . There was no evidence that the facility notified the residents of the Facility's comprehensive emergency management plan approval and implementation, and no evidence of an established policy and procedure.

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On , at 05:40 p.m., that Administrator provided the manufacture's manual, and stated that he was not aware that a policy and procedure was required. Administrator

Observation on at approximately 05:45 p.m., with the Administrator revealed that the Facility had six (five-gallon containers) for fuel. No fuel source was stored at the Facility. Administrator stated that he was under the impression that the County did not want Facility to store fuel onsite. Administrator did not provide documentation in writing on limitation of fuel on site by the County. The Administrator also confirmed that residents and responsible parties were not provided with written notice of implementation of the Facility's Emergency Power Plan.

Class III